CONRAD STATE 30 J-1 VISA STATE OF KANSAS
REQUESTING J-1 VISA WAIVER TRANSFER

Once a Kansas J-1 Visa Waiver application is approved for a specific location, the J-1 physician cannot be placed at another location without approval. Movement of a J-1 physician to a location that has not been approved by KDHE will result in the physician being out of compliance with the program and may be reported to USCIS.

** *Provide the U.S. Department of State J-1 visa waiver case number on all correspondence*

KDHE must be notified, in writing, of the J-1 physician's intent to transfer to another location along with the following information:

- Reasons for the transfer
- The proposed new employer, practice site name, address, telephone number
- Proposed date of transfer

The original employer must:

- Provide a letter releasing the J-1 physician from the employment contract
- Provide an explanation for termination

The new employer must:

- Provide a letter of intent to employ the J-1 physician for the remainder of the obligation period
- Agree to the terms that the J-1 physician will provide health services 40 hours per week
- Provide a copy of the employment contract
- Provide a copy of the sliding fee scale

Within 30 days of the transfer, the physician and the new employer must submit the J-1 Visa Waiver Transfer Notification Form to:

Attn: J-1 Visa Waiver Review Program
State Primary Care Office
KDHE Bureau of Community Health Systems
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

TRANSFER NOTIFICATION

Physician Name: _____

Home Address: _____
Street City State Zip

Date of Birth: _____ Origin of Birth: _____

Social Security # _____ Case # _____ Specialty_____

Phone: _____ Email Address: _____

Former Employer: _____

Complete Address: _____
Street City State Zip

Phone:_____ County: _____

Date of Transfer: _____ HPSA ID: _____

New Employer: _____

Complete Address: _____
Street City State Zip

Phone:_____ County: _____

HPSA ID: _____

I certify that I, the undersigned, do provide primary health care services at the new location a minimum of 40 hours per week.

_____ _____
J-1 Physician's Signature Date

I do hereby certify that Dr. _____began practicing at _____

on _____ and provides primary health care services at the new HPSA location a minimum of 40 hours per week.

_____ _____
Facility Representative (Please Print) Title

_____ _____
Facility Representative's Signature Date

Subscribed and sworn to before me
this_____ day of_____, 20____.
Notary Public